Rockrimmon Integrated Medical
425 W. Rockrimmon Blvd. Ste. 100, Colorado Springs, CO. 80919

VEHICLE ACCIDENT REPORT

Patient Information

Patient Name:_____ DOB:_____ Date:_____

Email:_____ Phone:_____ SS #:_____

Check appropriate Box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

☐Male ☐Female

Address:_____ City:_____ State: _____ Zip:_____

Whom may we thank for referring you? _____

Person to contact in case of an emergency: _____Phone:_____

Accident Information

Date of accident: _____ Time of accident____:____ (AM / PM)

What seat in the vehicle were you in?: _____ Were you wearing a seatbelt?:_____

Make & Model of Vehicle you were occupying: _____ How many people in this vehicle?: _____

Make & Model of other vehicle:_____ How many people in this vehicle?: _____

Did the police come to the accident site? Y N Was a police report filed? Y N Were there any witnesses? Y N

Did your Vehicle have Airbags? Y N If yes, did they inflate? Y N

Was a traffic violation issued? Y N If yes, to whom was it issued?:_____

How did the accident occur: A) Struck by another vehicle B) Struck another vehicle C) Struck a stationary object D) Other

Please explain: _____

_____

Where was your vehicle hit? A) Front B) Rear C) R. side D) L. side E) R. front F) L. front G) R. rear H) L. rear

Where was the other vehicle hit? A) Front B) Rear C) R. side D) L. side E) R. front F) L. front G) R. rear H) L. rear

Your approximate speed _____MPH Other vehicle approximate speed _____MPH

Which street/location/intersection were you traveling on and in which direction? _____

If accident vehicle made impact with another vehicle, which direction was it coming from?_____

Were you aware or surprised by the impact?_____ During impact, where were you facing?_____

In relation to the base of your skull, where was the headrest?_____

Did any part of your body strike anything in the vehicle? Please describe: _____

What occurred at the moment of impact? (Circle all that apply)

A) Tensed body for impact B) Neck whipped forward & back C) Spine torqued and twisted D) Thrown over seat

E) Thrown from vehicle F) Pinned in vehicle G) Thrown from side to side H) Cut and bruised

Were you rendered unconscious? Y N If yes, for how long?_____

Please describe how you felt immediately after the accident:_____

Did you receive medical attention at the scene of the accident? Y N Were you: A) Shaken B) Disoriented C)_____

Where did you go immediately following the accident? A) Hospital B) Home C) Personal doctor D) This office

Did you have any physical complaints before the accident? Y N If "Yes," please describe:_____

Since the accident, have you seen another healthcare provider? Y N If yes, who?_____

Circle the symptoms below that are a result of this accident (Circle all that apply and write in under "other")

Indicate your degree of comfort while performing the following activities: (mark the corresponding box)

Describe any treatment you received, including; medications prescribed, procedures performed and images taken (xrays, CT scan, MRI, etc.):_____

Have you been able to work since the injury? Y N. If yes, have your work activities been restricted by the accident? Y N

Is Your Condition getting worse? Y N Is it constant or do the symptoms come and go?: _____

Does your pain travel/radiate from one area to another? Y N Please describe_____

Does anything make your symptoms better?_____ Worse?_____

Print Name:_____ Sign Name:_____ Date:_____

Adult Patient ☐ Parent or Guardian of Patient ☐

Dizziness	Headaches	Jaw Problems	Nausea
Memory Loss	Irritability	Back Pain	Blurred Vision
Arm/Shoulder Pain	Difficulty Sleeping	Numb in Hands/Fingers	Numb in Feet/Toes
Fatigue	Back Stiffness	Low Back Pain	Buzzing in Ears
Chest Pain	Leg Pain	Short of Breath	Tension
Upset Stomach	Stiff Neck	Neck Pain	Ringing in Ears
Other	Other	Other	Other

	Comfortable	Uncomfortable	Painful
Stretching			
Lying on Side			
Lying on Back			
Lying on Stomach			
Sitting			
Standing			
Walking			
Running			
Sports			
Working			
Lifting			
Bending			
Kneeling			
Pulling			

Past Medical History

Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain)

AIDS & HIV	NO	YES	Whooping Cough	NO	YES	Heartburn	NO	YES	Date of Last Chest X-Ray
Chicken Pox	NO	YES	Cancer	NO	YES	Hemorrhoids	NO	YES	
Diphtheria	NO	YES	Anemia	NO	YES	Hernia	NO	YES	Any Other Disease NO YES
Hepatitis	NO	YES	Bleeding Tendency	NO	YES	Ulcer	NO	YES	List:
Infectious Mono	NO	YES	Chest Pain/ Angina	NO	YES	Hives or Eczema	NO	YES	
Measles	NO	YES	Heart Attack	NO	YES	Arthritis	NO	YES	
Mumps	NO	YES	Heart Murmur	NO	YES	Back Trouble	NO	YES	
Pneumonia	NO	YES	High Blood Pressure	NO	YES	Epilepsy	NO	YES	
Polio	NO	YES	Low Blood Pressure	NO	YES	Migraine Headache	NO	YES	
Rheumatic Fever	NO	YES	Mitral Valve			Stroke	NO	YES	
Loss of Urine	NO	YES	Prolapse	NO	YES	Glaucoma	NO	YES	
Scarlet Fever	NO	YES	Diabetes	NO	YES	Kidney Disease	NO	YES	
Small Pox	NO	YES	Thyroid Disease	NO	YES	Asthma	NO	YES	
Tuberculosis	NO	YES	Frequent Diarrhea	NO	YES	Bronchitis	NO	YES	
Veneral Disease	NO	YES	Gallbladder Dz	NO	YES	Bladder Infection	NO	YES	

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medication: (include nonprescription)

_____

_____

Are you taking any medications for acid indigestion? O yes O no if yes what type: _____

Supplements: _____

Patient Social History:

Use of Alcohol Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Drugs Never: _____ Type/Frequency:_____

Excessive Exposure

At home or at work to: Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: _____ Noise: _____

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father			
Mother			
Siblings			
Spouse			
Children			

Insurance Information

Was the accident your fault? _____ Do you have MedPay? _____ (the front desk can help you determine this)

Name of your Auto insurance company:_____ Your Claim Number: _____

Your Adjusters Name and Phone Number: _____

Name of At-Fault party's insurance company (if not the same as above): _____

At Fault Claim Number:_____ At Fault Adjusters Name/Number: _____

If minor please list name of Parent/Guardian _____

Have you retained an attorney?: Y N If yes, whom?_____

If you have retained an attorney, you must fill out the "Doctor's Lien" before undergoing care in this office.

Disclosure of Health Care Information (HIPAA)

I understand that my personal health information is private and confidential. The HIPAA Privacy Rule gives individuals the right to request restrictions on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of that a communication of PHI be made by alternative means. The providers and staff at Rockrimmon Integrated Medical, LLC, work hard to ensure the privacy and confidentiality of my personal health information. I understand that providers and staff at Rockrimmon Integrated Medical work to disclose to me personal health information to help provide health care, handle billing and information, and to take care of other health operations. I understand that I have the right to ask my provider to limit how my personal information is used or disclosed to carry out treatment, payment, or other health care operations.

I wish to be contacted in the following manner (Check all that apply):

( )By telephone _____ ( ) Work ( ) Cell ( ) Home

( ) It is OKAY to leave detailed message ( ) Message with call back number ONLY

( ) Written communication

( ) Okay to send mail to my home address

( ) Okay to send email to the following address _____

I hereby authorize Rockrimmon Integrated Medical, LLC to provide clinical information or answer questions regarding my care with (Check all that apply):

Name: _____ Relation to client: _____Phone Number:_____

( ) Information regarding treatment ( ) Lab results ( ) Appointment Information

Name: _____ Relation to client: _____Phone Number:_____

( ) Information regarding treatment ( ) Lab results ( ) Appointment Information

Patient Name_____

Patient Signature_____ **Date** _____

Consent to Treat

I hereby request and consent to the performance of therapeutic exercise monitored by a rehabilitation technician, chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below.

I can discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.
Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.
Radiographs: ionizing radiation can be harmful to a fetus for those **who are pregnant or might be pregnant.**
Lab Draws: bleeding at site of draw, bruising, nausea and loss of consciousness

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.

I understand that if I request a private consultation with the doctor to discuss personal health matters, upon my request, this private room with the doctor and a staff member will be provided.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name_____

Patient Signature_____ **Date** _____

Consent to evaluate and adjust a minor child

I, _____being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

X_____

Signature **Printed Name** **Date**